CORPUS CHRISTI – NUECES COUNTY

PUBLIC HEALTH DISTRICT

PREVENTION DIVISION – IMMUNIZATIONS CLINIC

1702 HORNE RD., CORPUS CHRISTI, TX 78416

PHONE: 361-826-7238 FAX: 361-826-7212

Authorization to Release Official Immunization Record

 COMPLETE ALL PORTIONS OF THIS FORM.

You must be a Parent, Legal Guardian, or Managing Conservator for the child (under the age of 18) whose record you are requesting. All immunization record requests must be accompanied by documents that identify the person requesting the immunization record. Examples of identification are: state issued driver’s license or ID, passport, school/work ID.

Anyone over the age of 18 must request their own immunization record.

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|  CLIENT’S INFORMATION |
| Last Name   | First Name | Middle Name |
| Date of Birth \_\_\_\_\_\_\_/ \_\_\_\_\_\_/ \_\_\_\_\_\_  Month Day Year  | Sex: M F | Previous Name(s) |
| Street Address  | Apt. # | City |
| County  | State  | Zip Code | Phone Number ( )  |
| REQUESTOR INFORMATION(if applicant is a minor)  |
| Are you the: Parent, Guardian, or Managing Conservator? | Yes | No | Relationship to child:  |
| Last Name   | First Name  | Middle Name | Maiden Name  |
| AUTHORIZED SIGNATURE |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Corpus Christi – Nueces County Public Health District Print name of (or Parent, Legal Guardian, or Managing Conservator for a child) to release this client’s official immunization record. I further release the aforesaid Corpus Christi – Nueces County Public Health District from all legal responsibility of liability that may arise from the act that I have authorized above.  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_  Client (or Parent, Legal Guardian, or Managing Conservator for child) Month Day Year  |
| RETENTION OF RECORDS(if applicant is 18 years old or older) |
| I understand that, by granting this consent, I am authorizing that my immunization records be retained in TWICES/IMMTRAC 2 and my immunization information may by law be accessed by a physician or other health care provider legally authorized for treating me as a patient.  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_  Client Month Day Year  |
| FOR OFFICE USE ONLY |
| Date Searched/Released:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Record Released  Record Not Found By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |